Adopt Ins 4000, to read as follows:

CHAPTER Ins 4000 UNIFORM REPORTING SYSTEM FOR HEALTH CARE CLAIMS DATA SETS

Statutory Authority: RSA 400-A:15 I; RSA 420-G:14

PART Ins 4001 PURPOSE AND SCOPE

Ins 4001.01 Purpose and Scope. This chapter contains the provisions for submission of health care claims data sets from third-party payers, third-party administrators, and carriers and health care claims processors that provide only administrative services for a plan sponsor.

PART Ins 4002 DEFINITIONS

Ins 4002.01 Definitions. Unless the context indicates otherwise, the following words and phrases shall have the following meanings:

(a) "Address" means street address, post office box numbers, apartment numbers, e-mail addresses, web universal resource locator (URL) and internet protocol (IP) address number.

(b) "Bank account" means any checking, savings, certificate of deposit, or any account utilized for the payment of third parties.

(c) "Capitated services" means services rendered by a provided through a contract in which payment are based upon a fixed dollar amount for each member on a monthly basis.

(d) "Carrier" means any entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health services, and includes an insurance company, a health maintenance organization, a nonprofit health services corporation, third party administrator or any other entity arranging for or providing health coverage.

(e) "Clinical data" means health care claims and information about health care claims for services delivered in hospitals or other setting.

(f) "Co-insurance" means the percentage a member pays toward the cost of a covered service.

(g) "Commissioner" means the insurance commissioner.

(h) "Confidential agency data" means data collected or produced by the department that:

(1) Has not been revealed to the general public;

(2) Can be withheld from public access without violation of RSA 91-A; and

(3) Shall not, in the opinion of the commissioner, be released.

(i) "Confidential clinical data" means data provided to the department that:

(1) Has not been revealed to the general public; and

(2) Relates to provision of medical or other services to a specific individual.

(j) "Confidential financial data" means data provided to the department that:

(1) Has not been revealed to the general public; and

(2) Shall directly result in the data provider being placed at a competitive economic disadvantage.

(k) "Consumer assessment of health plans survey" or "CAHPS" (CAPHS®) means a survey tool that measures consumer experience with carriers and health care claims processors.

(l) "Co-payment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

(m) "Data submission tool" or "DST" means the NCQA provided tool for submitting HEDIS data.

(n) "Department" or "NHID" means the New Hampshire insurance department.

(o) "Designee" means an entity with which the department and/or the department of health and human services have entered into an arrangement pursuant to which the entity performs data management and collecting functions, and under which the entity is strictly prohibited from using or releasing the information and data obtained in such a capacity for any purposes other than those specified in the agreement.

(p) "DHHS" means the department of health and human services.

(q) "Direct identifier" means any information, other than case or code numbers used to create anonymous or encrypted data, that plainly discloses the identity of an individual, including:

(1) Names;

(2) Postal address information other than town or city, state and zip code;

(3) Telephone and fax numbers;

(4) Electronic mail addresses;

(5) Social security numbers;

(6) Vehicle identifiers and serial numbers;

(7) Personal internet ID addresses and URLs;

(8) Biometric identifiers, including finger and voice prints; and

(9) Personal photographic images.

(r) "Disclosure" means, with respect to clinical or financial data, to communicate information to a person not already in possession of that information or to use information for a purpose not originally authorized.

(s) "Family" means spouse, children, parents, siblings, and legal guardians.

(t) "Financial data" means information collected that includes, but is not limited to:

(1) Costs of operation;

(2) Revenues;

(3) Assets;

(4) Liabilities;

(5) Fund balances;

(6) Other income;

(7) Rates;

(8) Charges; and

(9) Units of services.

(u) "Health care claims data" means information consisting of, or derived directly from, member eligibility, medical claims, and pharmacy claims, files submitted by health care claims processors. "Health care data" does not include analysis, reports, or studies containing information from health care claims data sets, if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by the department.

(v) "Health care claims processor" means a third-party payer, third-party administrator, or carrier that provides administrative services for a plan sponsor.

(w) "Health care practitioner" means physicians and all others certified, registered or licensed in the healing arts, including, but not limited to:

(1) Nurses;

(2) Podiatrists;

(3) Optometrists;

(4) Pharmacists;

(5) Chiropractors;

(6) Physical therapists;

(7) Dentists;

(8) Psychologists; and

(9) Physicians' assistants.

(x) "HEDIS®" means the set of performance measures in the managed care industry that were developed and are maintained by the National Committee for Quality Assurance (NCQA) covering various areas of measurement from general health plan information to utilization rates.

(y) "Hospital" means a licensed acute or specialty care institution.

(z) "Insured" means an individual in whose name an insurance policy is carried.

(aa) "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to:

(1) Member demographics;

(2) Provider information;

(3) Charge/payment information; and

(4) Clinical diagnosis/procedure codes.

(ab) "Member" means the subscriber and any spouse and/or dependent who is covered by the subscriber's policy.

(ac) "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

(ad) "National Committee for Quality Assurance" or "NCQA" means the private, not-for-profit organization that assesses and reports on the quality of the nation's managed care plans through an accreditation and performance measurement program, including quality of care, member satisfaction, access and customer service.

(ae) "Non-hospital provider" means a provider of health care services other than a hospital.

(af) "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to:

(1) Member demographics;

(2) Provider information;

(3) Charge/payment information; and

(4) National drug codes.

(ag) "Plan sponsor" means any persons, other than an insurer, who establishes or maintains a plan covering residents of the state of New Hampshire, including, but not limited to, plans established or maintained by employers or jointly by one or more employers and one or more employee organizations, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

(ah) "Prepaid amount" means the fee for the service equivalent that would have been paid by the health care claims processor for a specific service if the service had not been capitated.

(ai) "Privileged medical information" means information other than hospital, non-hospital health care facility, or health care claims data that identifies individual patients and that is derived from communications that were:

(1) Made for the purpose of diagnosis or treatment among a provider or health care, persons assisting the provider or patient, and a patient;

(2) Made for the purpose of payment of health care services among a provider of health care, a health care claims processor, and a patient;

(3) Not intended to be disclosed except to persons necessary to transmit or record the communication and persons participating in the diagnosis, treatment or payment; and

(4) Not previously disclosed to the general public.

(aj) "Provider" means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.

(ak) "Release" means to make data or information available for inspection and copying to persons other than the data provider.

(al) "Subscriber" means the certificateholder.

(am) "Third party administrator" means any persons licensed by the department, that, on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of the state.

(an) "Third party payer" means a state agency that pays for health care services or a health insurer, nonprofit hospital, medical services organization, or managed care organization licensed in the state of New Hampshire.

PART Ins 4003 REPORTING REQUIREMENTS FOR ALL LICENSED CARRIERS AND HEALTH CARE CLAIMS PROCESSORS

Ins 4003.01 HEDIS reporting requirements. Each carrier that collects data for use in calculating health plan employer data and information set managed care measures shall report those data that are collected and that pertain to members or subscribers who receive their benefits under a policy or plan issued in New Hampshire. The carrier shall use the NCQA DST tool for submission of HEDIS data to the DHHS, or to their designees, by July 31st of each year, beginning in July 2005.

Ins 4003.02 CAHPS reporting requirements. Each carrier that collects CAHPS survey data shall report those data collected that are collected and that pertain to members or subscribers who receive their benefits under a policy or plan issued in New Hampshire. The carrier shall use the NCQA tab and banner format for submission of the CAHPS survey data to the DHHS, or to their designees by July 31st of each year, beginning in July 2005.

PART Ins 4004 HEALTH CARE CLAIMS DATA SET FILING

Ins 4004.01 Data set filing description.

(a) Beginning on June 1, 2005, and continuing thereafter in accordance wit the submission schedule set forth in Ins 4005.05, each carrier and each health care claims processor shall submit to the NHID and to the DHHS, or their designee, a completed health care claims data set for all members who receive services under a policy issued in New Hampshire. Each health care claims processor and each carrier shall also submit all health care claims processed by any sub-contractor on its behalf. The health care claims data set shall including a member eligibility file, a medical claims file, and a pharmacy claims file.

(b) The NHID and the DHHS, or their designee, shall provide a phone number, e-mail address and mailing address of a contact person who can provide information on the status of data files submitted.

(c) The NHID and the DHHS shall also provide an electronic newsletter or other method of communicating information to plans and carriers and health care claims processors regarding the receipt, processing and loading of data files.

(d) Third party payers that write less than $250,000 in accident and health insurance premiums in New Hampshire on an annual basis shall not be required to submit their health care claims data set, their HEDIS data, or their CAHPS survey data.

(e) Third party administrators that administer health insurance plans covering fewer than 200 New Hampshire lives in total shall not be required to submit their health claims data.

(f) In instances where more than one entity is involved in the administration of a policy, the health carrier shall be responsible for submitting the claims data on policies that it has written, and the third party administrator shall be responsible for submitting claims data on self-insured plans that it administers.

(g) The NHID and/or the DHHS may enter into an agreement with a third party designee to collect and process the data. The agreement shall provide that the third party designee shall be strictly prohibited from collecting any social security numbers or direct identifiers and from releasing or using data or information obtained in its capacity as a collector and processor of the data for any purposes other than those specifically authorized by the agreement. The agreement shall provide that the designee shall transmit all data that it collects and processes to the NHID and the DHHS.

Ins 4004.02 General requirements for data submission.

(a) Adjustment records. Carriers and health care claims processors shall report adjustment records with the appropriate positive or negative fields with the medical and pharmacy file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

(b) Capitated services claims. Claims for capitated services shall be reported with all medical and pharmacy file submissions.

(c) Data fields. Carriers and health care claims processors shall make every effort to report the data fields outlined in these requirements. However, if a field is not used for medical or pharmacy claim adjudication, is not captured on the carrier's transaction system (nor on that of its subcontractors), or cannot be derived reliably from other information available on the carrier's transaction system, the health plan shall notify the NHID and the DHHS, or their designee, and shall identify the field that cannot be provided. After notification, the carrier shall not be required to populate that data field in its reports. The carrier shall report on an annual basis its efforts to populate this field, and the expected data as of which this field will be available, if there is such a data.

(d) Claimant and member records. Claims records and member records for medical and pharmacy claims shall be reported only for members who receive their benefits under a policy or plan issued in New Hampshire.

(e) Claim records. Records for medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical, and pharmacy claims shall be based upon the paid dates and not upon the dates of service associated with the claims.

(f) Code sources. Unless otherwise specified, the following code sources are to be utilized in association with the member eligibility file and medical and pharmacy claims files submissions. The required source codes are as follows:

(1) **Admission Source Code (Data Element: MC021)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining who recommended admission to a medical facility.

(2) **Admission Type Code (Data Element: MC020)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining the priority of the admission to a medical facility.

(3) **Current Procedural Terminology (CPT) Codes (Data Element: MC055)**

SOURCE: Physicians' Current Procedural Terminology (CPT) Manual

AVAILABLE FROM:
Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

(4) **Health Care Common Procedural Coding System (Data Element: MC055)**

SOURCE: Health Care Common Procedural Coding System

AVAILABLE FROM:
www.cms.gov/medicare/hcpcs.htm
Centers for Medicare and Medicaid Services
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

(5) **Centers for Medicare and Medicaid Services National Plan ID (Data Elements: DC002, HD003, MC002, ME002, PC002, TR003)**

SOURCE: Plan ID Database

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Centers for Beneficiary Services
Administration Group
Division of Membership Operations
SI-05-06
7500 Security Boulevard

Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the Plan ID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

(6) **Centers for Medicare and Medicaid Services National Provider Identifier (Data Elements: DC020, MC026)**

SOURCE: National Provider System

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Office of Information Services
Security and Standards Group
Director, Division of Health Care Information Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the National Provider Identifiers, which is proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

(7) **International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure (Data Elements: MC040, MC041, MC043, MC044, MC045, MC046, MC047, MC048, MC049, MC050, MC051, MC052, MC053, MC058)**

SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

AVAILABLE FROM:
U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

(8) **National Association of Boards of Pharmacy Number (Data Element: PC021)**

SOURCE: National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM:
National Council for Prescription Drug Program
4201 North 24th Street
Suite 365
Phoenix, AZ 85016

ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The

National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

(9) **National Association of Insurance Commissioners (NAIC) Code (Data Elements: DC001, HD002, MC001, ME001, PC001, TR002)**

SOURCE: National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM:
National Association of Insurance Commissioners
Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT: Codes that uniquely identify each insurance company.

(10) **National Drug Code (Data Element: PC026)**

SOURCE: Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM:
First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

(11) **National Uniform Billing Committee (NUBC) Codes (Data Element: MC054)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

(12) **Member Status Code (Data Element: MC023)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee

American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes indicating member status as of the date of service-thru field.

(13) **States and Outlying Areas of the U.S.**
(Data Elements: DC015, DC028, MC015, MC034, ME016, PC015, PC023)

SOURCE: National Zip Code and Post Office Directory

AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S. Microfiche.

(14) **Uniform Billing Claim Form Bill Type (Data Element: MC036)**

SOURCE: National Uniform Billing Data Element Specifications Type of Bill Positions 1 and 2

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes describing the type of medical facility.

(15) **X12 Directories**

SOURCE: X12.3 Data Element Directory; X12.22 Segment Directory

AVAILABLE FROM:
Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT: The data element directory contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment director contains the format and definitions of the data segments used to construct the X12 transaction sets.

(16) **ZIP Code (Data Elements: DC016, DC029, MC016, MC035, ME017, PC016, PC024)**

SOURCE: National Zip Code and Post Office Directory, Publication 65, The USPS Domestic Mail Manual

AVAILABLE FROM:
U.S. Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT: The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the nine digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery service area. The two leftmost digits identify a sector that may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit ZIP code.

(g) Member Identification Codes. Carriers and health care claims processors shall assign, according to a standard algorithm provided b the NHID and the DHHS, or their designee, a unique identification code to each of their members that is the member's encrypted social security number. If a health care claims processor does not collect the social security numbers for its members, the health care claims processor shall encrypt the social security number of the subscriber and assigned a discrete two digit suffix for each member under the subscribers contract.

(1) If the subscriber's social security number is not collected by the health care claims processor, an encrypted version of the subscriber's certificate or contract number shall be used in its place. The NHID shall provide a standard encrypted algorithm. The discrete two digit suffix shall also be used with the encrypted certificate or contract number. The encrypted certificate or contract number with the two digit suffix shall be at least 11, but no more than 30 characters in length.

(2) For encrypting the social security number of the member/subscriber, the carrier and health care claims processor shall utilize a standard methodology provided by the NHID. The unique member identification code assigned by each carrier and health care claims processor shall remain with each member for the entire period of coverage for that individual.

(3) Specific/Unique Coding. With the exception of provider codes and provider specialty codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(4) Co-insurance/Co-payment. Co-insurance and co-payment are to be reported in 2 separate fields in the medical and pharmacy claims file submission.

(5) Coordination of Benefit Claims. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

(6) Version Number: When more than one version of a fully-processed claim service line is submitted, each version of a claim service line shall be enumerated sequentially with a

higher version number (MC005A). The latest version of that service line shall be the record with the highest version number (MC005A) and the same claim number + line counter.

(7) Fully-Processed Claim Lines: Only fully-processed claim service lines that have gone through an accounts payable run and been booked to the health plan ledger shall be included on medical and pharmacy claims data submissions.

(8) Denied Claims. Denied claims shall be excluded from all medical and pharmacy claims file submissions whenever possible. When a claim contains both fully-processed paid service lines and partially processed or denied service lines, an effort shall be made to include only the fully-processed, paid service lines as part of the health care claims data set submittal.

(9) Subsequent incremental claims submissions shall include all reversal and adjustment/restated versions of previously submitted claim service lines and all new, fully-processed service lines associated with the claim, provided that they have paid dates in the reporting period. Each version of a claim service line shall be enumerated sequentially with a higher line version number (MC005A). Reversal versions of a claim service line shall be indicated by a claim status code = '22' (Field MC038).

a. If a claim contains service lines that have been denied because their costs are covered on another line of the claim line, such as under a global payment arrangement, those denied line(s) shall be included in the data submission. These lines shall be clearly indicated by a claim status code = '04' (Field MC038).

b. Carriers and health care claims processors that are unable to exclude denied claims or service lines without compromising the completeness of their claims submission shall be allowed to submit all versions of fully-processed paid and denied claims service lines, provided that lines and versions thereof are clearly indicated by a claim status code = '04', and the line version number is sequentially noted on any reversal and adjustment versions of those lines to clearly indicate the order in which all changes to these lines were processed.

(10) Eligibility Records. Records for the member eligibility submission shall be reported at the individual member level. If a member is covered as both a subscriber and a dependent on 2 different policies during the same month, 2 records shall be submitted. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records shall be submitted.

(11) Carriers and health care claims processors shall not be required to resend eligibility data for a prior reporting period, for the purpose of capturing retroactive charges. Retroactive charges shall not be considered errors in the submitted eligibility data.

(12) Carriers and health care claims processors that submit data quarterly shall include one member record for each calendar month in which a member was covered. One record shall be submitted for each reporting month in which the member was eligible for medical or pharmacy benefits for one or more days.

(13) Medical Claims File Exclusions. Stand-alone insurance policies issued for the following types of services are not covered by this rule. Claims processed under policies that provide stand-alone coverage for dental, specific disease, accident, injury, hospital indemnity, disability, long-term care, vision coverage, or durable medical equipment shall be excluded from the medical claims file submission. Claims for these types of services shall be included in the medical claims file submission if they are covered by a comprehensive medical insurance policy.

(14) All claims related to behavorial or mental health shall be included in the medical claims file. Claims related to Medicare, Tricare, or other supplemental health insurance policies are to be excluded unless the policies are for health care services entirely excluded by the

Medicare, Tricare, or other program. Claims for pharmacy services containing national drug codes are also to be excluded from the medical claims file.

(15) Member Eligibility File Exclusions. Members without medical and/or pharmacy coverage during the month reported shall be excluded.

(16) Pharmacy Claims File Exclusions. Pharmacy services claims generated from non-retail pharmacies that do not contain national drug codes shall be included in the medical claims file and not the pharmacy claims file. If high-cost, injectible, or other specialty outpatient prescription claims (e.g., oncology, hemophilia, or infertility medicates) are processed by the health plan's pharmacy benefits manager and coded using national drug codes, these claims shall be included in the pharmacy claims file. Claims that are submitted as standard UB92, NSF, or ANSI 935 formatted transactions without NDE codes, shall be included on the medical claims file.

(h) File Format. Each data file submission shall be an ASCII file, variable field length, and asterisk delimited. When asterisks are used in any field values, they shall be enclosed in double quotes.

(i) Header and Trailer Records. Each member eligibility file and each medical claims file, and pharmacy claims file that is submitted shall contain a header record and a trailer record. The header record is the first record of each separate file that is submitted and the trailer records is the last record of each submitted file. The header and trailer record formant shall conform to the following record specifications:

(1) Record Specifications. Health care claims processors and carriers shall use the following record specifications in submitting their claims records:

a. The file header record layout shall be submitted using the following data elements:

1. HD001. This element is named "record type". The data type of this element is text. Its length is 2.

2. HD002. This element is named "payer". The data type of this element is text. Its length is 6. Carriers and health care claims processors shall code according to payer submitting payments, NHID submitter code.

3. HD003. This element is named "National Plan ID". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to CMS National Plan ID.

4. HD004. This element is named "type of file". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code according to NH member eligibility, MC medical claims, PC pharmacy.

5. HD005. This element is named "period beginning date". The data type of this element is integer. Its length is 6. Carriers and health care claims processors shall code according to CCYYMM, beginning of paid period for claims, beginning of month covered for eligibility.

6. HD006. This element is named "period ending date". The data type of this element is integer. Its length is 6. Carriers and health care claims processors shall code according to CCYYMM, end of paid period for claims, end of month covered for eligibility.

7. HD007. This element is named "record count". The data type of this element is integer. Its length is 10. Carriers and health care claims

processors shall code according to total number of records submitted in this file, with the header and trailer record excluded from the count.

8. HD008. This element is named "comments". The data type of this element is text. Its length is 80. Carriers and health care claims processors shall code according to their own option.

b. The file header record layout shall conform to the following format:

Data Element #	Element	Type	Maximum Length	Description/Codes/Sources
HD001	**Record Type**	Text	2	HD
HD002	**Payer**	Text	6	Payer submitting payments
				NHID Submitter Code
HD003	**National Plan ID**	Text	30	CMS National Plan ID
HD004	**Type of File**	Text	2	NH Member Eligibility
				MC Medical Claims
				PC Pharmacy Claims
HD005	**Period Beginning Date**	Integer	6	CCYYMM
				Beginning of paid period for claims
				Beginning of month covered for eligibility
HD006	**Period Ending Date**	Integer	6	CCYYMM
				End of paid period for claims
				End of month covered for eligibility
HD007	**Record Count**	Integer	10	Total number of records submitted in this file
HD008	**Comments**	Text	80	Submitted may use to document this submission by assigning a filename, system source, etc.

c. The trailer header record layout shall be submitted using the following data elements:

1. TR001. This element is named "record type". The data type of this element is text. Its length is 2.

2. TR002. This element is named "payer". The data type of this element is text. Its length is 6. Carriers and health care claims processors shall code according to payer submitting payments, NHID submitter code.

3. TR003. This element is named "National Plan ID". The date type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to CMS National Plan ID.

4. TR004. This element is named "type of file". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code according to NH member eligibility, MC medical claims, PC pharmacy claims.

5. TR005. This element is named "period beginning date". The data type of this element is integer. Its length is 6. Carriers and health care claims processors shall code according to CCYYMM, beginning of paid period for claims, beginning of month covered for eligibility.

6. TR006. This element is named "period ending date". The date type of this element is integer. Its length is 6. Carriers and health care claims processors shall code according to CCYYMM, end of paid period for claims, end of month covered for eligibility.

7. TR007. This element is named "date processed". The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code according to CCYYMMDD, the date the file was created.

d. The trailer record layout shall conform to the following format:

Data Element #	Element	Type	Maximum Length	Description/Codes/Sources
TR001	**Record Type**	Text	2	TR
TR002	**Payer**	Text	6	Payer submitting payments
				NHID Submitter Code
TR003	**National Plan ID**	Text	30	CMS National Plan ID
TR004	**Type of File**	Text	2	NH Member Eligibility
				MC Medical Claims
				PC Pharmacy Claims
TR005	**Period Beginning Date**	Integer	6	CCYYMM
				Beginning of paid period for claims
				Beginning of month covered for eligibility
TR006	**Period Ending Date**	Integer	6	CCYYMM
				End of paid period for claims
				End of month covered for eligibility
TR007	**Date Processed**	Date	8	CCYYMMDD
				Date file was created

(j) Prepaid Amount. Any prepaid amounts shall be reported in a separate filed in the medical and pharmacy claims file submissions.

(k) Detailed File Specifications. All carriers and health care claims processors shall use the following file specifications in their submissions:

(1) Filled Fields. All fields shall be filled where applicable. Non-applicable text and date fields shall be set to null. Non-applicable integer and decimal fields shall be filled with one zero and shall not include decimal points.

(2) Position. All text fields shall be left justified. All integer and decimal fields shall be right justified.

(3) Signs. All signs (+ or -) shall appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals shall not be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB92, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file type shall conform to the following file specifications:

a. The specifications for the member eligibility file shall be as follows:

1. ME001. This element is named "payer". The data type of this element is text. Its length is 6. Carriers and health care claims processors shall code according to payer submitting payments, NHID submitter code.

2. ME002. This element is named "National Plan ID". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to CMS National Plan ID.

3. ME003. This element is named "insurance type code/product". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code according to the following chart:

Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12-month coordination period with an Employer Group Health Plan
14	Medicare Secondary No-Fault Insurance including Insurance in which Auto is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary Other Liability Insurance is Primary
AP	Auto Insurance Policy
CP	Medicare Conditionally Primary

D	Disability
DB	Disability Benefits
EP	Exclusive Provider Organization
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
SP	Supplemental Policy
WC	Workers' Compensation

4. ME004. This element is named "year". The data type of this element is integer. Its length is 4. Carriers and health care claims processors shall code according to the year for which eligibility is reported in this submission.

5. ME005. This element is named "month". The date type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to the month for which eligibility is reported in this submission.

6. ME006. This element is named "insured group or policy number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the group or policy number and not the number that uniquely identifies the subscriber.

7. ME007. This element is named "coverage level code". The data type of this element is text. Its length is 3. Carriers and health care claims processors shall code according to the benefit coverage level:

(i) CHD Children Only;

(ii) DEP Dependents Only;

(iii) ECH Employee and Children;

(iv) EMP Employee Only;

(v) ESP Employee and Spouse;

(vi) FAM Family;

(vii) IND Individual;

(viii) SPC Spouse and Children; and

(ix) SPO Spouse Only.

8. ME008. This element is named "encrypted subscriber social security number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted subscriber's social security number. Carriers and health care claims processors shall set as null if unavailable.

9. ME009. This element is named "plan specific contact number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted plan assigned contract number. Carriers and health care claims processors shall set as null if contract number is the same as the subscriber's social security number.

10. ME010. This element is named "member suffix or sequence number". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to the unique number of the member within the contract.

11. ME011. This element is named "member identification code". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted member's social security number, and carriers and health care claims processors shall set as null if the social security number is unavailable.

12. ME012. This element is named "individual relationship code". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to the member's relationship to the insured as shown on the following chart:

Code	Description
01	Spouse
18	Self/Employee
19	Child
21	Unknown
34	Other Adult

13. ME013. This element is named "member gender". The data type of this element is text. Its length is one. Carriers and health care claims processors shall code according to:

(i) M = Male;

(ii) F = Female; and

(iii) U = Uknown.

14. ME014. This element is named "member date of birth". The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code according to CCYYMMDD.

15. ME015. This element is named "member city name". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the city location of the member.

16. ME016. This element is named "member state or province". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code as defined by the U.S. Postal Service.

17. ME017. This element is named "member zip code". The data type of this element is text. Its length is 11. Carriers and health care claims processors shall code according to ZIP code of member, which may include non-US codes. Carriers and health care claims processors shall not include the dash in the coding.

18. ME018. This element is named "medical coverage". The data type of this element is text. Its length is one. Carriers and health care claims processors shall code according to:

(i) Y = Yes; and

(ii) N = No.

19. ME019. This element is named "prescription drug coverage". The data type of this element is text. Its length is one. Carriers and health care claims processors shall code according to:

(i) Y = Yes; and

(ii) N = No.

20. ME020. This element is named "record type". The data type of this element is text. Its length is 2. Its value is literally "ME".

b. The specifications for the member eligibility file shall be submitted using the following layout:

Data Element #	Element	Type	Max. Length	Description/Codes/Sources
ME001	Payer	Text	6	Payer submitting payments
				NHID Submitter Code
ME002	National Plan ID	Text	30	CMS National Plan ID
ME003	Insurance Type Code/Product	Text	2	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
				13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12-month coordination period with an Employer Group Health Plan
				14 Medicare Secondary, No-fault insurance including insurance in which auto is primary
				15 Medicare Secondary Workers' Compensation
				16 Medicare Secondary Public Health Service or Other Federal Agency
				41 Medicare Secondary Black Lung
				42 Medicare Secondary Veterans Administration
				43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
				47 Medicare Secondary, Other Liability Insurance is Primary
				AP Auto Insurance Policy
				CP Medicare Conditionally Primary
				D Disability
				DB Disability Benefits
				EP Exclusive Provider Organization
				HM Health Maintenance Organization (HMO)
				HN Health Maintenance Organization (HMO) Medicare Risk
				HS Special Low Income Medicare Beneficiary
				IN Indemnity
				LC Long Term Care
				LD Long Term Policy
				LI Life Insurance
				LT Litigation
				MA Medicare Part A
				MB Medicare Part B

				MC Medicaid
				MH Medigap Part A
				MI Medigap Part aB
				MP Medicare Primary
				PR Preferred Provider Organization (PPO)
				PS Point of Service (POS)
				QM Qualified Medicare Beneficiary
				SP Supplemental Policy
				WC Workers' Compensation
ME004	Year	Integer	4	Year for which eligibility is reported in this submission
ME005	Month	Integer	2	Month for which eligibility is reported in this submission
ME006	Insured Group or Policy Number	Text	30	Group or policy number (not the number that uniquely identifies the subscriber)
ME007	Coverage Level Code	Text	3	Benefit Coverage Level
				CHD Children Only
				DEP Dependents Only
				ECH Employee and Children
				EMP Employee Only
				ESP Employee and Spouse
				FAM Family
				IND Individual
				SPC Spouse and Children
				SPO Spouse Only
ME008	Encrypted Subscriber Social Security Number	Text	30	Encrypted subscriber's social security number (*set as null if unavailable*)
ME009	Plan Specific Contract Number	Text	30	Encrypted plan assigned contract number (*set as null if contract number = subscriber's social security* numbe)r
ME010	Member Suffice or Sequence Number	Integer	2	Uniquely numbers the member within the contract
ME011	Member Identification Code	Text	30	Encrypted member's social security number (*set as null if unavailable*)
ME012	Individual Relationship Code	Integer	2	Member's relationship to insured
				01 Spouse
				18 Self/Employee
				19 Child
				21 Unknown
				34 Other Adult
ME013	Member Gender	Text	1	M Male
				F Female

				U Unknown
ME014	Member Date of Birth	Date	8	CCYYMMDD
ME015	Member City Name	Text	30	City name of member
ME016	Member State or Province	Text	2	As defined by the US Postal Service
ME017	Member ZIP Code	Text	11	ZIP Code of member – may include non-US codes. (Do not include dash)
ME018	Medical Coverage	Text	1	Y Yes
				N No
ME019	Prescription Drug Coverage	Text	1	Y Yes
				N No
ME020	Record Type	Text	2	ME

c. The member eligibility file shall be mapped to a national standard format that conforms to the following:

Data Element #	**Element**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
ME001	Payer	N/A
ME002	National Plan ID	271/2100A/NM1/XV/09
ME003	Insurance Type Code/Product	271/2110C/EB/ /04, 271/2110D/EB/ /04
ME004	Year	N/A
ME005	Month	N/A
ME006	Insured Group or Policy Number	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
ME007	Coverage Level Code	271/2110C/EB/ /03, 271/2100D/EB/ /03
ME008	Encrypted Subscriber Social Security Number	271/2100C/NM1/MI/09
ME009	Plan Specific Contract Number	271/2100C/NM1/MI/09
ME010	Member Suffix or Sequence Number	N/A
ME011	Member Identification Code	271/2100C/MN1/MI/09, 271/2100D/NM1/MI/09
ME012	Individual Relationship Code	271/2100C/INS/Y/02, 271/2100D/INS/N/02
ME013	Member Gender	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
ME015	Member City Name	271/2100C/N4/ /01, 271/2100D/N4/ /01

ME016	Member State or Province	217/2100C/N4/ /02, 271/2100D/N4/ /02
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A
ME019	Prescription Drug Coverage	N/A
ME020	Record Type	N/A

d. Medical claim file shall be submitted using the following data elements:

1. MC001. This element is named "payer". The data type of this element is text. Its length is 6. Carriers and health care claims processors shall code according to the payer submitting payments, NHID submitter code.

2. MC002. This element is named "national plan ID". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the CMS national plan ID.

3. MC003. This element is named "insurance type/product code". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code according to the following chart:

Code	**Description**
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
DS	Disability
HM	Health Maintenance Organization
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
VA	Veterans Administration Plan
WC	Workers' Compensation

4. MC004. This element is named "payer claim control number". The data type of this element is text. Its length is 35. Carriers and health care claims processors shall code according to the entire claim and be unique within the payer's system.

5. MC005. This element is named "line counter". The data type of this element is integer. Its length is 4. Carriers and health care claims processors shall code according to line number for this service. The line counter shall begin with one and shall be incremented by one for each additional line of a claim.

6. MC005A. This element is named "version number". The data type of this element is integer. Its length is 4. Carriers and health care claims processors shall code according to version number of this claim service line. The version number begins with zero, and is incremented by one for each subsequent version of that service line.

7. MC006. This element is named "insured group or policy number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the group or policy number, not the number that uniquely identifies the subscriber.

8. MC007. This element is named "encrypted subscriber social security number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted subscriber's social security number. Carriers and health care claims processors shall set as null if unavailable.

9. MC008. This element is named "plan specific contract number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted plan assigned. Carriers and health care claims processors shall set as null if the contract number is the same as the subscriber's social security number.

10. MC009. This element is named "member suffix or sequence number". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to the unique number of the member within the contract.

11. MC010. This element is named "member identification code". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted member's social security number. Carriers and health care claims processors shall set as null if unavailable.

12. MC011. This element is named "individual relationship code". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to member's relationship to insured as shown on the following chart:

Code	**Description**
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employer
21	Unknown

22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent

13. MC012. This element is named "member gender". The data type of this element is text. Its length is one. Carriers and health care claims processors shall code according to:

(i) M Male;

(ii) F Female; and

(iii) U Unknown.

14. MC013. This element is named "member date of birth". The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code according to CCYYMMDD.

15. MC014. This element is named "member city name". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the city name of the member.

16. MC015. This element is named "member state or province". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code as defined by the U.S. Postal Service.

17. MC016. This element is named "member ZIP code". The data type of this element is text. Its length is 11. Carriers and health care claims processors shall code according to ZIP Code of member. This may include non-US codes. Carriers and health care claims processors shall not use the dash in coding.

18. MC017. This element is named "date service approved" (AP Date). The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code according to CCYYMMDD, which is generally the same as the paid date.

19. MC018. This element is named "admission date". The data type of this element is date. Its length is 12. Carriers and health care claims processors shall code for all inpatient claims using CCYYMMDD.

20. MC019. This element is named "admission hour". The data type of this element is integer. Its length is 4. Carriers and health care claims processors shall code for all inpatient claims, and shall express time in military time, HHMM.

21. MC020. This element is named "admission type". The data type of this element is text. Its length is one. Carriers and health care claims processors shall code using an integer.

22. MC021. This element is named "admission source". The data type of this element is text. Its length is one. Carriers and health care claims processors shall code using text.

23. MC022. This element is named "discharge hour". The data type of this element is integer. Its length is two. Carriers and health care claims processors shall code using military time.

24. MC023. This element is named "member status". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code as shown in the following chart:

Code	**Description**
01	Discharged to home or self care
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to nursing facility (NF)
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to this hospital
20	Expired
30	Still patient or expected to return for outpatient services

25. MC024. This element is named "service provider number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code using the payer assigned provider number.

26. MC025. This element is named "service provider tax ID number". The data type of this element is text. Its length is 10. Carriers and health care claims processors shall code using the federal taxpayer's identification number.

27. MC026. This element is named "national service provider ID". The data type of this element is text. Its length is 20. Carriers and health care claims processors shall code if national provider ID is mandated for use under HIPAA.

28. MC027. This element is named "service provider entity type qualifier". The data type of this element is text. Its length is one. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person", and these shall be coded as a person. Carriers and health care claims processors shall code according to

(i) One = Person; and

(ii) 2 = Non-person entity

29. MC028. This element is named "service provider first name". The data type of this element is text. Its length is 25. Carriers and health care claims processors shall code according to the individual's first name, and set to null if the provider is a facility or organization.

30. MC029. This element is named "service provider middle name". The data type of this element is text. Its length is 25. Carriers and health care claims processors shall code according to the entity's middle name or initial, and shall set to null if provider is a facility or organization.

31. MC030. This element is named "service provider last name or organization name". The data type of this element is text. Its length is 25. Carriers and health care claims processors shall code using the full name of the provider organization or last name of individual provider.

32. MC031. This element is named "service provider suffix". The data type of this element is text. Its length is 10. Carriers and health care claims processors shall code according to the suffix to the individual name, and set to null if the provider is a facility or organization. The service provider suffix shall be used to capture the generation of individual clinician (e.g., Jr., Sr., III.), if applicable, rather than the clinician's degree (e.g., MD, LICSW).

33. MC032. This element is named "service provider specialty". The data type of this element is text. Its length is 10. Carriers and health care claims processors shall code as defined by the payer dictionary for specialty code value, which shall be supplied during testing.

34. MC033. This element is named "service provider city name". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the city name of provider, and preferably the practice location.

35. MC034. This element is named "service provider state". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code as defined by the US Postal Service.

36. MC035. This element is named "service provider ZIP Code". The data type of this element is text. The length is 11. Carriers and health care claims processors shall code according to ZIP code of provider, which may include non-US codes. Carriers and health care claims processors shall not use the dash in coding.

37. MC036. This element is named "type of bill institutional". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall use this coding on facility claims, including those submitted using UB92 forms, according to the following chart:

First Digit	**Type of Facility**
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
5	Christian Science Extended Care
6	Intermediate Care
7	Clinic
8	Special Facility
Second Digit if First Digit = 1 through 6	**Bill Classification**
1	Inpatient (including Medicare Part A)
2	Inpatient (including Medicare Part B Only)
3	Outpatient
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Nursing Facility Level I
6	Nursing Facility Level II
7	Intermediate Care – Level III Nursing Facility
8	Swing Beds
Second Digit if First Digit = 7	**Bill Classification**
1	Rural Health
2	Hospital Based or Independent Renal
3	Dialysis Center
4	Free Standing
5	Outpatient Rehabilitation Facility (ORF)
6	Comprehensive Outpatient Rehabilitation
7	Facilities (CORFs)
9	Other
Second Digit if First Digit = 8	**Bill Classification**
1	Hospice, Non-hospital based
2	Hospital, Hospital based
3	Ambulatory Surgery Center

4	Free Standing Birthing Center
9	Other

38. MC037. This element is named "facility type professional". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall use this coding on professional claims, including those submitted using NSF CMS 1500 forms, according to the following chart:

Code	**Facility**
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance –Air or Water
50	Federally Qualified Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State of Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

39. MC038. This element is named "claim status". The data type of this element is integer. Its length is 2. This code describes the payment status of the specific service line record. Carriers and health care claims processors shall code according to the following:

(i) 01 Processed as primary;

(ii) 02 Processed as secondary;

(iii) 03 Processed as tertiary;

(iv) 04 Denied;

(v) 19 Processed as primary, forwarded to additional payer(s);

(vi) 20 Processed as secondary, forwarded to additional payer(s);

(vii) 21 Processed as tertiary, forwarded to additional payer(s); and

(viii) 22 Reversal of previous payment.

40. MC039. This element is named "admitting diagnosis". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code according to all inpatient admission claims and encounters using the ICD-9-CM without the decimal point.

41. MC040. This element is named "E-code". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall use this code to describe an injury, poisoning or adverse effect, ICD-9-CM without coding decimal points.

42. MC041. This element is named "principal diagnosis". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code the principal diagnosis given on the claim header using CD-9-CM without coding decimal points.

43. MC042. This element is named "other diagnosis – 1". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

44. MC043. This element is named "other diagnosis – 2". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

45. MC044. This element is named "other diagnosis – 3". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

46. MC045. This element is named "other diagnosis – 4". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

47. MC046. This element is named "other diagnosis – 5". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

48. MC047. This element is named "other diagnosis – 6". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

49. MC048. This element is named "other diagnosis – 7". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

50. MC049. This element is named "other diagnosis – 8". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

51. MC050. This element is named "other diagnosis – 9". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

52. MC051. This element is named "other diagnosis – 10". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

53. MC052. This element is named "other diagnosis – 11". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

54. MC053. This element is named "other diagnosis – 12". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code using ICD-9-CM without coding decimal points.

55. MC054. This element is named "revenue code". The data type of this element is text. Its length is 4. Carriers and health care claims processors shall code using national uniform billing committee codes. Carriers and health care claims processors shall code using leading zeroes, left-justified, and four digits.

56. MC055. This element is named "procedure code". The data type of this element is text. Its length is 5. Carriers and health care claims processors shall code according to the Health Care Common Procedural Coding System (HCPCS). This includes the CPT codes of the American Medical Association.

57. MC056. This element is named "procedure modifier – 1". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code using a procedure modifier when a modifier clarifies or improves the reporting accuracy of the associated procedure code.

58. MC057. This element is named "procedure modifier – 2". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code using a procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.

59. MC058. This element is named "ICD-9-CM procedure code". The data type of this element is text. Its length is 4. Carriers and health care claims processors shall code using the primary ICD-9-CM code given on the claim header without coding decimal points.

60. MC059. This element is named "date of service – from". The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code using the first date of service for this service line, CCYYMMDD.

61. MC060. This element is named "date of service – thru". The data type of this element is date. Its length is 8. Carriers and health care claims

processors shall code using the last date of service for this service line, CCYYMMDD.

62. MC061. This element is named "quantity". The data type of this element is integer. Its length is 3. Carriers and health care claims processors shall code according to count of services performed, which shall be set equal to one on all observation bed service lines.

63. MC062. This element is named "charge amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code according to the charge without coding decimal points.

64. MC063. This element is named "paid amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code including withhold amounts without coding decimal points.

65. MC064. This element is named "prepaid amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code using for capitated services, the fee for service equivalent amount without coding decimal points.

66. MC065. This element is named "co-pay amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code using the preset, fixed dollar amount for which the individual is responsible without coding decimal points.

67. MC066. This element is named "coinsurance amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code using the dollar amount of the coinsurance without coding decimal points.

68. MC067. This element is named "deductible amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code using the dollar amount of the deductible without coding decimal points.

69. MC068. This element is named "record type". The data type of this element is text. Its length is 2.

e. The file specification for the medical claim file shall conform to the following format:

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
MC001	**Payer**	Text	6	Payer submitting payments
				NHID Submitter Code
MC002	**National Plan ID**	Text	30	CMS National Plan ID
MC003	**Insurance Type/Product Code**	Text	2	12 Preferred Provider Organization (PPO)

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				13 Point of Service (POS)
				14 Exclusive Provider Organization (EPO)
				15 Indemnity Insurance
				16 Health Maintenance Organization (HMO) Medicare Risk
				DS Disability
				HM Health Maintenance Organization
				MA Medicare Part A
				MB Medicare Part B
				MC Medicaid
				VA Veteran Administration Plan
				WC Worker's Compensation
MC004	**Payer Claim Control Number**	Text	35	Must apply to the entire claim and be unique within the payer's system
MC005	**Line Counter**	Integer	4	Line number for this service
				The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
MC005A	**Version Number**	Integer	4	Version number of this claim service line
				The version number begins with 0 and is incremented by 1 for each subsequent version of that service line
MC006	**Insured Group or Policy Number**	Text	30	Group or policy number (not the number that uniquely identifies the subscriber
MC007	**Encrypted Subscriber Social Security Number**	Text	30	Encrypted subscriber's social security number *Set as null if unavailable*
MC008	**Plan Specific Contract Number**	Text	30	Encrypted plan assigned *Set as null if contract number = subscriber's social security number*
MC009	**Member Suffix or Sequence Number**	Integer	2	Uniquely numbers the member within the contract
MC010	**Member Identification Code**	Text	30	Encrypted member's social security number Set as null if unavailable
MC011	**Individual Relationship Code**	Integer	2	Member's relationship to insured
				01 Spouse
				04 Grandfather or Grandmother
				05 Grandson or Granddaughter
				07 Nephew or Niece
				10 Foster Child
				15 Ward
				17 Stepson or Stepdaughter
				19 Child

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				20 Employee
				21 Unknown
				22 Handicapped Dependent
				23 Sponsored Dependent
				24 Dependent of a Minor Dependent
				29 Significant Other
				32 Mother
				33 Father
				36 Emancipated Minor
				39 Organ Donor
				40 Cadaver Donor
				41 Injured Plaintiff
				43 Where Insured Has No Financial Responsibility
				53 Life Partner
				76 Dependent
MC012	**Member Gender**	Text	1	M Male
				F Female
				U Unknown
MC013	**Member Date of Birth**	Date	8	CCYYMMDD
MC014	**Member City Name**	Text	30	City name of member
MC015	**Member State or Province**	Text	2	As defined by the US Postal Service
MC016	**Member ZIP Code**	Text	11	ZIP Code of member - may include non-US codes
MC017	**Date Service Approved (AP Date)**	Date	8	CCYYMMDD
				(Generally the same as the paid date)
MC018	**Admission Date**	Date	12	Required for all inpatient claims
				CCYYMMDD
MC019	**Admission Hour**	Integer	4	Required for all inpatient claims
				Time is expressed in military time – HHMM
MC020	**Admission Type**	Integer	1	
MC021	**Admission Source**	Text	1	
MC022	**Discharge Hour**	Integer	2	Hour in military time
MC023	**Member Status**	Integer	2	01 Discharged to home or self care
				02 Discharged/transferred to another short-term general hospital for inpatient care

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				03 Discharged/transferred to skilled nursing facility (SNF)
				04 Discharged/transferred to nursing facility (NF)
				05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
				06 Discharged/transferred to home under care of organized home health service organization
				07 Left against medical advice or discontinued care
				08 Discharged/transferred to home under care of a Home IV provider
				09 Admitted as an inpatient to this hospital
				20 Expired
				30 Still patient or expected to return for outpatient services
MC024	**Service Provider Number**	Text	30	Payer assigned provider number
MC025	**Service Provider Tax ID Number**	Text	10	Federal taxpayer's identification number
MC026	**National Service Provider ID**	Text	20	Required if National Provider ID is mandated for use under HIPAA
MC027	**Service Provider Entity Type Qualifier**	Text	1	1 Person 2 Non-Person Entity
				HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as “Person”.
MC028	**Service Provider First Name**	Text	25	Individual first name
				Set to null if provider is a facility or organization
MC029	**Service Provider Middle Name**	Text	25	Individual middle name or initial
				Set to null if provider is a facility or organization
MC030	**Service Provider Last Name or Organization Name**	Text	35	Full name of provider organization or last name of individual provider
MC031	**Service Provider Suffix**	Text	10	Suffix to individual name
				Set to null if provider is a facility or organization. Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than the clinician’s degree [e.g., ‘MD’, ‘LICSW’].
MC032	**Service Provider**	Text	10	As defined by payer

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
	Specialty			
				Dictionary for specialty code values must be supplied during testing
MC033	**Service Provider City Name**	Text	30	City name of provider - preferably practice location
MC034	**Service Provider State**	Text	2	As defined by the US Postal Service
MC035	**Service Provider ZIP Code**	Text	11	ZIP Code of provider - may include non-US codes Do not include dash
MC036	**Type of Bill – Institutional**	Integer	2	**Type of Facility - First Digit**
	(Should be coded on facility claims, such as those submitted using on UB92 forms)			1 Hospital
				2 Skilled Nursing
				3 Home Health
				4 Christian Science Hospital
				5 Christian Science Extended Care
				6 Intermediate Care
				7 Clinic
				8 Special Facility
				Bill Classification - Second Digit if First Digit = 1-6
				1 Inpatient (Including Medicare Part A)
				2 Inpatient (Medicare Part B Only)
				3 Outpatient
				4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
				5 Nursing Facility Level I
				6 Nursing Facility Level II
				7 Intermediate Care - Level III Nursing Facility
				8 Swing Beds
				Bill Classification - Second Digit if First Digit = 7
				1 Rural Health
				2 Hospital Based or Independent Renal
				3 Dialysis Center
				4 Free Standing
				5 Outpatient Rehabilitation Facility (ORF)
				6 Comprehensive Outpatient Rehabilitation
				7 Facilities (CORFs)
				9 Other
				Bill Classification – Second Digit if First Digit = 8
				1 Hospice (Non Hospital Based
				2 Hospice (Hospital-Based)

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				3 Ambulatory Surgery Center
				4 Free Standing Birthing Center
				9 Other
MC037	**Facility Type – Professional**	Text	2	11 Office
	(Should be coded on professional claims, such as those submitted using on NSF [CMS 1500 forms])			12 Home
				21 Inpatient Hospital
				22 Outpatient Hospital
				23 Emergency Room – Hospital
				24 Ambulatory Surgery Center
				25 Birthing Center
				26 Military Treatment Facility
				31 Skilled Nursing Facility
				32 Nursing Facility
				33 Custodial Care Facility
				34 Hospice
				41 Ambulance – Land
				42 Ambulance – Air or Water
				51 Inpatient Psychiatric Facility
				52 Psychiatric Facility Partial Hospitalization
				53 Community Mental Health Center
				54 Intermediate Care Facility/Mentally Retarded
				55 Residential Substance Abuse Treatment Facility
				56 Psychiatric Residential Treatment Center
				50 Federally Qualified Center
				60 Mass Immunization Center
				61 Comprehensive Inpatient Rehabilitation Facility
				62 Comprehensive Outpatient Rehabilitation Facility
				65 End Stage Renal Disease Treatment Facility
				71 State of Local Public Health Clinic
				72 Rural Health Clinic
				81 Independent Laboratory
				99 Other Unlisted Facility
MC038	**Claim Status**	Integer	2	01 Processed as primary
	(Actually describes the payment status of the specific service line record)			02 Processed as secondary
				03 Processed as tertiary
				04 Denied
				19 Processed as primary, forwarded to additional payer(s)
				20 Processed as secondary, forwarded to additional

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				payer(s)
				21 Processed as tertiary, forwarded to additional payer(s)
				22 Reversal of previous payment
MC039	**Admitting Diagnosis**	Text	5	Required on all inpatient admission claims and encounters
				ICD-9-CM Do not code decimal point
MC040	**E-Code**	Text	5	Describes an injury, poisoning or adverse effect
				ICD-9-CM Do not include decimal
MC041	**Principal Diagnosis**	Text	5	ICD-9-CM Do not code decimal point
	This should be the principal diagnosis given on the claim header.			
MC042	**Other Diagnosis – 1**	Text	5	ICD-9-CM Do not code decimal point
MC043	**Other Diagnosis – 2**	Text	5	ICD-9-CM Do not code decimal point
MC044	**Other Diagnosis – 3**	Text	5	ICD-9-CM Do not code decimal point
MC045	**Other Diagnosis – 4**	Text	5	ICD-9-CM Do not code decimal point
MC046	**Other Diagnosis – 5**	Text	5	ICD-9-CM Do not code decimal point
MC047	**Other Diagnosis – 6**	Text	5	ICD-9-CM Do not code decimal point
MC048	**Other Diagnosis – 7**	Text	5	ICD-9-CM Do not code decimal point
MC049	**Other Diagnosis – 8**	Text	5	ICD-9-CM Do not code decimal point
MC050	**Other Diagnosis – 9**	Text	5	ICD-9-CM Do not code decimal point
MC051	**Other Diagnosis – 10**	Text	5	ICD-9-CM Do not code decimal point
MC052	**Other Diagnosis – 11**	Text	5	ICD-9-CM Do not code decimal point
MC053	**Other Diagnosis – 12**	Text	5	ICD-9-CM Do not code decimal point
MC054	**Revenue Code**	**Text**	**4**	National Uniform Billing Committee Codes
				Code using leading zeroes, left-justified, and four digits.
MC055	**Procedure Code**	Text	5	Health Care Common Procedural Coding System (HCPCS)
				This includes the CPT codes of the

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				American Medical Association
MC056	**Procedure Modifier – 1**	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the
				associated procedure code
MC057	**Procedure Modifier – 2**	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC058	**ICD-9-CM Procedure Code**	Text	4	Primary ICD-9-CM code given on the claim header. Do not code decimal point
MC059	**Date of Service – From**	Date	8	First date of service for this service line
				CCYYMMDD
MC060	**Date of Service – Thru**	Date	8	Last date of service for this service line
				CCYYMMDD
MC061	**Quantity**	Integer	3	Count of services performed
				Should be set equal to 1 on all Observation bed service lines, for consistency.
MC062	**Charge Amount**	Decimal	10	Do not code decimal point
MC063	**Paid Amount**	Decimal	10	Includes any withhold amounts
				Do not code decimal point
MC064	**Prepaid Amount**	Decimal	10	For capitated services, the fee for service equivalent amount
				Do not code decimal point
MC065	**Copay Amount**	Decimal	10	The preset, fixed dollar amount for which the individual is responsible Do not code decimal point
MC066	**Coinsurance Amount**	Decimal	10	Do not code decimal point
MC067	**Deductible Amount**	Decimal	10	Do not code decimal point
MC068	**Record Type**	Text	2	MC

f. The mapping for medical claims file shall conform to the following national standard format:

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
MC001	Payer	N/A	N/A	N/A	N/A	N/A
MC002	National Plan ID	N/A	N/A	N/A	N/A	835/1000A/N1/XV/04
MC003	Product/Claim Filing Indicator Code	N/A	30/4	N/A	N/A	835/2100/CLP/ /06
MC004	Payer Claim Control Number	N/A	N/A	N/A	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0	835/2100/CLP/ /07
MC005	Line Counter	N/A	N/A	N/A	N/A	837/2400/LX/ /01
MC006	Insured Group or Policy Number	62 (A-C)	30/10	11C	DA0-10.0	837/2000B/SBR/ /03
MC007	Encrypted Subscriber Social Security Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC008	Plan Specific Contract Number	N/A	N/A	N/A	N/A	835/2100/NM1/HN/08
MC009	Member Suffix or Sequence Number	N/A	N/A	N/A	N/A	N/A
MC010	Member Identification Code	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC011	Individual Relationship Code	59 (A-C)	30/18	6	DA0-17.0	37/2000B/SBR/ /02, 37/2000C/PAT/ /01
MC012	Member Gender	15	20/7	3	CA0-09.0	837/2010CA/DMG/03
MC013	Member Date of Birth	14	20/8	3	CA0-08.0	2010CA/DMG/D8/02
MC014	Member City Name	13	20/14	5	CA0-13.0	837/2010CA/N4/ /01

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
MC015	Member State or Province	13	20/15	5	CA0-14.0	837/2010CA/N4/ /02
MC016	Member ZIP Code	13	20/16	5	CA0-15.0	837/2010CA/N4/ /03
MC017	Date Service Approved	N/A	N/A	N/A	N/A	N/A
MC018	Admission Date	17	20/17	N/A	N/A	837/2300/DTP/435/03
MC019	Admission Hour	18	20/18	N/A	N/A	837/2300/DTP/435/03
MC020	Admission Type	19	20/10	N/A	N/A	837/2300/CL1/ /01
MC021	Admission Source	20	20/11		N/A	837/2300/CL1/ /02
MC022	Discharge Hour	21	20/22		N/A	837/2300/DTP/096/03
MC023	Member Status	22	20/21	N/A	N/A	837/2300/CL1/ /03
MC024	Service Provider Number	N/A	N/A	N/A	N/A	N/A
MC025	Service Provider Tax ID Number	5	10/4-5	25	BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0,BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0,BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0	835/2100/NM1/FI/09
MC026	National Service Provider ID	N/A	10/6	N/A	N/A	835/2100/NM1/XX/09
MC027	Service Provider Entity Type Qualifier	N/A	N/A	N/A	N/A	835/2100/NM1/82/02
MC028	Service Provider First Name	1	10/12	33	BA0-20.0	835/2100/NM1/82/04
MC029	Service Provider Middle Name	1	10/12	33	BA0-21.0	835/2100/NM1/82/05
MC030	Service Provider Last Name or Organization Name	1	10/12	33	BA0-18.0, BA0-19.0	835/2100/NM1/82/03
MC031	Service Provider Suffix	1	10/12	33	BA0-22.0	835/2100/NM1/82/07
MC032	Service Provider Specialty	N/A	N/A	N/A	N/A	837/2000A/PRV/ZZ/03
MC033	Service Provider City Name	1	10/14	N/A	BA1-09.0, 15.0	837/2010A/N4/ /01
MC034	Service Provider State or	1	10/15	N/A	BA1-10.0, 16.0	837/2010A/N4/ /02

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
	Province					
MC035	Service Provider ZIP Code	1	10/16	N/A	BA1-11.0, 17.0	837/2010A/N4/ /03
MC036	Type of Bill – Institutional	4	Positions 1-2: 40/4	N/A	N/A	837/2300/CLM/ /05-1
MC037	Facility Type - Professional	N/A	N/A	N/A	FA0-07.0, GU0-0.50	835/2100/CLP/ /08
MC038	Claim Status	N/A	N/A	N/A	N/A	835/2100/CLP/ /02
MC039	Admitting Diagnosis	76	70/25	N/A	N/A	837/2300/HI/BJ/02-2
MC040	E-Code	77	70/26	N/A	N/A	837/2300/HI/BN/03-2
MC041	Principal Diagnosis	67	70/4	21.1	EA0-32.0, GX0-31.0, GU0-12.0	837/2300/HI/BK/01-2
MC042	Other Diagnosis – 1	68	70/5	21.2	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-1
MC043	Other Diagnosis – 2	69	70/6	21.3	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-2
MC044	Other Diagnosis – 3	70	70/7	21.4	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-3
MC045	Other Diagnosis – 4	71	70/8	N/A	EA0-35.0, GX0-34.0, GU0-15.0	837/2300/HI/BF/02-4
MC046	Other Diagnosis – 5	72	70/9	N/A	N/A	837/2300/HI/BF/02-5
MC047	Other Diagnosis – 6	73	70/10	N/A	N/A	837/2300/HI/BF/02-6
MC048	Other Diagnosis – 7	74	70/11	N/A	N/A	837/2300/HI/BF/02-7
MC049	Other Diagnosis – 8	75	70/12	N/A	N/A	837/2300/HI/BF/02-8
MC050	Other Diagnosis – 9	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-9
MC051	Other Diagnosis –10	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-10
MC052	Other Diagnosis –11	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-11
MC053	Other Diagnosis –12	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-12
MC054	Revenue Code	42	50/5,11-13, 60/5,15-16, 61/5,15-16	N/A	N/A	835/2110/SVC/RB/01-2, 835/2110/SVC/NU/01-2
MC055	Procedure Code	44	60/6,15-16, 61/6,15-	24.1-6 D	FA0-09.0, FB0-15.0, GU0-	835/2110/SVC/HC/01-2

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
			16		07.0	
MC056	Procedure Modifier – 1	44	60/7,15-16, 61/7, 15-16	24.1-6 D	FA0-10.0, GU0-08.0	835/2110/SVC/HC/01-3
MC057	Procedure Modifier – 2	44	60/8,15-16, 61/8,15-16	24.1-6 D	FA0-11.0	835/2110/SVC/HC/01-3
MC058	ICD-9-CM Procedure Code	80, 81(A-E)	70/13, 15, 17, 19, 21, 23	N/A	N/A	835/2110/SVC/ID/01-2
MC059	Date of Service – From	45	61/13, 15-16, 61/13, 15-16	24.1-6 A	N/A	835/2110/DTM/150/02
MC060	Date of Service – Thru	N/A	N/A	24.1-6 A	FA0-05.0, FA0-06.0	835/2110/DTM/151/02
MC061	Quantity	46	50/7, 11-13, 60/9,15-16, 61/9,15-16	24.1-6 G	FA0-19.0, FB0-16.0	835/2110/SVC/ /05
MC062	Charge Amount	47	50/8, 11-13, 60/10, 16-16, 61/11, 15-16	24.1-6F	FA0-13.0	835/2110/SVC/ /02
MC063	Paid Amount	48	N/A	N/A	N/A	835/2110/SVC/ /03
MC064	Prepaid Amount	N/A	N/A	N/A	N/A	N/A
MC065	Co-pay Amount	N/A	N/A	N/A	N/A	N/A
MC066	Coinsurance Amount	N/A	N/A	N/A	N/A	N/A
MC067	Deductible Amount	N/A	N/A	N/A	N/A	N/A
MC068	Record Type	N/A	N/A	N/A	N/A	N/A

g. The pharmacy claim file layout shall be submitted using the following format:

1. PC001. This element is named "payer". The data type of this element is text. Its length is 6. Carriers and health care claims providers shall code using the payer submitting payments, NHID submitter code.

2. PC002. This element is named "plan ID". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code using the CMS national plan ID.

3. PC003. This element is named "insurance type/product code". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code according to the following chart:

Code	**Description**
12	Preferred Provider Organization (PPO)
13	Point of Servcie (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Party B
MC	Medicaid
OF	Other Federal Program (e.g. Black Lung)
TV	Title V
VA	Veterans Administration Plan
WC	Workers' Compensation

4. PC004. This element is named "payer claim control number". The data type of this element is text. Its length is 35. Carriers and health care claims processors shall code using the entire claim, which shall be unique within the payer's system.

5. PC005. This element is named "line counter". The data type of this element is integer. Its length is 4. Carriers and health care claims processors shall code according to line number for this service. The line counter shall begin with one and be incrementally increased by one for each additional service line of a claim.

6. PC006. This element is named "insured group number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to group or policy number and not the number that uniquely identifies the subscriber.

7. PC007. This element is named "encrypted subscriber social security number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted subscriber's social security number. Carriers and healthcare claims processors shall set as null if unavailable.

8. PC008. This element is named "plan specific contract number. The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the encrypted plan assigned contract number. Carriers and health care claims processors shall set as null if contract number is the same as subscriber's social security number.

9. PC009. This element is named "member suffix or sequence number". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to the unique number that identifies the member within the contract.

10. PC010. This element is named "member identification code". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the member's encrypted social security number. Carriers and health care claims processors shall set as null if unavailable.

11. PC011. This element is named índividual relationship code". Code. The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to member's relationship to insured according to the following chart:

Code	**Description**
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employee/Self
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner

76	Dependent

12. PC012. This element is named "member gender". The data type of this element is integer. Its length is 1. Carriers and health care claims processors shall code according to the following chart:

Code	Description
1	Male
2	Female
3	Unknown

13. PC013. This element is named "member date of birth". The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code according to CCYYMMDD.

14. PC014. This element is named "member city name of residence. The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the city name of member.

15. PC015. This element is named "member state". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code as defined by the US Postal Service.

16. PC016. This element is named "member ZIP code". The data type of this element is text. Its length is 9. Carriers and health care claims processors shall code according to the ZIP Code of member, which may include non-US codes. Carriers and health care claims processors shall not include dash.

17. PC017. This element is named "date service approved" (AP Date). The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code according to CCYYMMDD. This date is generally the same as the paid date or the pharmacy benefits manager's billing date.

18. PC018. This element is named "pharmacy number". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to payer assigned pharmacy number. An AHFS number is acceptable.

19. PC019. This element is named "pharmacy tax ID number". The data type of this element is text. Its length is 10. Carriers and health care claims processors shall code according to Federal taxpayer's identification number. (Carriers and health care claims processors shall provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.).

20. PC020. This element is named "pharmacy name". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the name of pharmacy.

21. PC021. This element is named "national pharmacy ID number. The data type of this element is text. Its length is 20. Carriers and health care

claims processors shall code according to the national provider ID, if that is mandated for use under HIPAA.

22. PC022. This element is named "pharmacy location city". The data type of this element is text. Its length is 30. Carriers and health care claims processors shall code according to the city name of pharmacy.

23. PC023. This element is named "pharmacy location state". The data type of this element is text. Its length is 2. Carriers and health care claims processors shall code as defined by the US Postal Service.

24. PC024. This element is named "pharmacy ZIP code". The data type of this element is text. Its length is 10. Carriers and health care claims processors shall code according to ZIP code of pharmacy, which may include non-US codes. Carriers and health care claims processors shall not include the dash in their codes.

25. PC025. This element is named "claim status". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to:

(i) 01 Processed as primary;

(ii) 02 Processed as secondary;

(iii) 03 Processed as tertiary;

(iv) 04 Denied;

(v) 19 Processed as primary, forwarded to additional payer(s);

(vi) 20 Processed as secondary, forwarded to additional payer(s);

(vii) 21 Processed as tertiary, forwarded to additional payer(s); and

(viii) 22 Reversal of previous payment.

26. PC026. This element is named "drug code". The data type of this element is text. Its length is 11. Carriers and health care claims processors shall code according to NDC Code.

27. PC027. This element is named "drug name". The data type of this element is text. Its length is 80. Carriers and health care claims processors shall code according to text name of drug.

28. PC028. This element is named "new prescription". The data type of this element is text. Its length is 1. Carriers and health care claims processors shall code according to:

(i) N = new prescription; and

(ii) R = refill prescription.

29. PCO28A. This element is named "refill number". The data type of this element is integer. Its length is 2. Carriers and health care claims processors shall code according to 01-99 Number of refill. If the refill number is unknown, or if this is a new prescription, then code as null.

30. PC029. This element is named "generic drug indicator". The data type of this element is text. Its length is 1. Carriers and health care claims processors shall code according to:

(i) N = No, branded drug; and

(ii) Y = Yes, generic drug.

31. PC030. This element is named "dispense as written code". The data type of this element is integer. Its length is one. Carriers and health care claims processors shall code according to:

(i) 0 = Not dispensed as written;

(ii) 1 = Physician dispense as written;

(iii) 2 = Member dispense as written;

(iv) 3 = Pharmacy dispense as written;

(v) 4 = No generic available;

(vi) 5 = Brand dispensed as generic;

(vii) 6 = Override;

(viii) 7 = Substitution not allowed, brand drug mandated by law;

(ix) 8 = Substitution allowed, generic drug not available in marketplace; and

(x) 9 = Other.

32. PC031. This element is named "compound drug indicator. The data type of this element is text. Its length is one. Carriers and health care claims processors shall code according to:

(i) N = Non-compound drug;

(ii) Y = Compound drug; and

(iii) U = Non-specified drug compound.

33. PC032. This element is named "date prescription filled". The data type of this element is date. Its length is 8. Carriers and health care claims processors shall code according to CCYYMMDD.

34. PC033. This element is named "quantity dispensed". The data type of this element is integer. Its length is 5. Carriers and health care claims processors shall code according to the number of metric units of medication dispensed.

35. PC034. This element is named "days supply". The data type of this element is integer. Its length is 3. Carriers and health care claims processors shall code according to estimated number of days the prescription will last.

36. PC035. This element is named "charge amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code according to the charge, without coding decimal points.

37. PC036. This element is named "paid amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code according to "includes all health plan payments and excludes all member payments", without coding decimal points.

38. PC037. This element is named "ingredient cost/list price". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code according to cost of the drug dispensed, without coding decimal points.

39. PC038. This element is named "postage amount claimed". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall not code decimal points.

40. PC039. This element is named "dispensing fee". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code according to the fee, without coding decimal points. points.

41. PC040. This element is named "co-pay amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code according to the preset, fixed dollar amount for which the individual is responsible, without coding decimal points.

42. PC041. This element is named "coinsurance amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall code not code decimal points.

43. PC042. This element is named "deductible amount". The data type of this element is decimal. Its length is 10. Carriers and health care claims processors shall not code decimal points.

44. PC043. This element is named "record type". The data type of this element is text. Its length is 2.

h. The specifications for the pharmacy claims file layout shall conform to the following format:

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
PC001	**Payer**	Text	6	Payer submitting payments
				NHID Submitter Code
PC002	**Plan ID**	Text	30	CMS National Plan ID
PC003	**Insurance Type/Product Code**	Text	2	12 Preferred Provider Organization (PPO)
				13 Point of Service (POS)
				14 Exclusive Provider Organization (EPO)
				15 Indemnity Insurance
				16 Health Maintenance Organization (HMO) Medicare Risk
				AM Automobile Medical
				DS Disability
				HM Health Maintenance Organization
				LI Liability
				LM Liability Medical
				MA Medicare Part A
				MB Medicare Part B
				MC Medicaid
				OF Other Federal Program (e.g. Black Lung)
				TV Title V
				VA Veteran Administration Plan
				WC Worker's Compensation
PC004	**Payer Claim Control Number**	Text	35	Must apply to the entire claim and be unique within the payer's system
PC005	**Line Counter**	Integer	4	Line number for this service
				The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
PC006	**Insured Group Number**	Text	30	Group or policy number - not the number that uniquely identifies the subscriber

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
PC007	**Encrypted Subscriber Social Security Number**	Text	30	Encrypted subscriber's social security number Set as null if unavailable
PC008	**Plan Specific Contract Number**	Text	30	Encrypted plan assigned contract number
				Set as null if contract number = subscriber's social security number
PC009	**Member Suffix or Sequence Number**	Integer	2	Uniquely numbers the member within the contract
PC010	**Member Identification Code**	Text	30	Encrypted member's social security number Set as null if unavailable
PC011	**Individual Relationship Code**	Integer	2	Member's relationship to insured
				01 Spouse
				04 Grandfather or Grandmother
				05 Grandson or Granddaughter
				07 Nephew or Niece
				10 Foster Child
				15 Ward
				17 Stepson or Stepdaughter
				19 Child
				20 Employee/Self
				21 Unknown
				22 Handicapped Dependent
				23 Sponsored Dependent
				24 Dependent of a Minor Dependent
				29 Significant Other
				32 Mother
				33 Father
				36 Emancipated Minor
				39 Organ Donor
				40 Cadaver Donor

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
				41 Injured Plaintiff
				43 Child Where Insured Has No Financial Responsibility
				53 Life Partner
				76 Dependent
PC012	**Member Gender**	Integer	1	1 Male
				2 Female
				3 Unknown
PC013	**Member Date of Birth**	Date	8	CCYYMMDD
PC014	**Member City Name of Residence**	Text	30	City name of member
PC015	**Member State**	Text	2	As defined by the US Postal Service
PC016	**Member ZIP Code**	Text	9	ZIP Code of member - may include non-US codes Do not include dash
PC017	**Date Service Approved (AP Date)**	Date	8	CCYYMMDD *(Generally the same as the paid date or the Pharmacy Benefits Manager's billing date)*
PC018	**Pharmacy Number**	Text	30	Payer assigned pharmacy number
				AHFS number is acceptable
PC019	**Pharmacy Tax ID Number**	Text	10	Federal taxpayer's identification number *(Please provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.)*
PC020	**Pharmacy Name**	Text	30	Name of pharmacy
PC021	**National Pharmacy ID Number**	Text	20	Required if National Provider ID is mandated for use under HIPAA

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
PC022	**Pharmacy Location City**	Text	30	City name of pharmacy - preferably pharmacy location
PC023	**Pharmacy Location State**	Text	2	As defined by the US Postal Service
PC024	**Pharmacy ZIP Code**	Text	10	ZIP Code of pharmacy - may include non-US codes Do not include dash
PC025	**Claim Status**	Integer	2	01 Processed as primary
				02 Processed as secondary
				03 Processed as tertiary
				04 Denied
				19 Processed as primary, forwarded to additional payer(s)
				20 Processed as secondary, forwarded to additional payer(s)
				21 Processed as tertiary, forwarded to additional payer(s)
				22 Reversal of previous payment
PC026	**Drug Code**	Text	11	NDC Code
PC027	**Drug Name**	Text	80	Text name of drug
PC028	**New Prescription**	Integer	2	00 New prescription
				01-99 Number of refill
				('01' should be used for all refills, if the specific number of the prescription refill is not available.)
PC029	**Generic Drug Indicator**	Text	1	N No, branded drug
				Y Yes, generic drug
PC030	**Dispense as Written Code**	Integer	1	0 Not dispensed as written
				1 Physician dispense as written
				2 Member dispense as written

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
				3 Pharmacy dispense as written
				4 No generic available
				5 Brand dispensed as generic
				6 Override
				7 Substitution not allowed - brand drug mandated by law
				8 Substitution allowed - generic drug not available in marketplace
				9 Other
PC031	**Compound Drug Indicator**	Text	1	N Non-compound drug
				Y Compound drug
				U Non-specified drug compound
PC032	**Date Prescription Filled**	Date	8	CCYYMMDD
PC033	**Quantity Dispensed**	Integer	5	Number of metric units of medication dispensed
PC034	**Days Supply**	Integer	3	Estimated number of days the prescription will last
PC035	**Charge Amount**	Decimal	10	Do not code decimal point
PC036	**Paid Amount**	Decimal	10	Includes all health plan payments and excludes all member payments
				Do not code decimal point
PC037	**Ingredient Cost/List Price**	Decimal	10	Cost of the drug dispensed
				Do not code decimal point
PC038	**Postage Amount Claimed**	Decimal	10	Do not code decimal point
PC039	**Dispensing Fee**	Decimal	10	Do not code decimal point
PC040	**Copay Amount**	Decimal	10	The preset, fixed dollar amount for which the individual

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
				Is responsible
				Do not code decimal point
PC041	**Coinsurance Amount**	Decimal	10	Do not code decimal point
PC042	**Deductible Amount**	Decimal	10	Do not code decimal point
PC043	**Record Type**	Text	2	PC

i. The pharmacy claims file shall be mapped to a national standard format which is as follows:

Data Element #	Element	National Council for Prescription Drug Programs Field #
PC001	Payer	N/A
PC002	Plan ID	N/A
PC003	Insurance Type/Product Code	N/A
PC004	Payer Claim Control Number	N/A
PC005	Line Counter	N/A
PC006	Insured Group Number	301-C1
PC007	Encrypted Subscriber Social Security Number	302-C2
PC008	Plan Specific Contract Number	N/A
PC009	Member Suffix or Sequence Number	N/A
PC010	Member Identification Code	302-CY
PC011	Individual Relationship Code	306-C6
PC012	Member Gender	305-C5
PC013	Member Date of Birth	304-C4
PC014	Member City Name of Residence	323-CN
PC015	Member State or Province	324-CO
PC016	Member ZIP Code	325-CP
PC017	Date Service Approved (AP Date)	N/A
PC018	Pharmacy Number	202-B2
PC019	Pharmacy Tax ID Number	N/A
PC020	Pharmacy Name	833-5P
PC021	National Pharmacy ID Number	N/A
PC022	Pharmacy Location City	831-5N
PC023	Pharmacy Location State	832-6F
PC024	Pharmacy ZIP Code	835-5R
PC025	Claim Status	N/A
PC026	Drug Code	407-D7
PC027	Drug Name	516-FG
PV028	New Prescription	403-D3
PC029	Generic Drug Indicator	N/A
PC030	Dispense as Written Code	408-D8
PC031	Compound Drug Indicator	406-D6
PC032	Date Prescription Filled	401-D1
PC033	Quantity Dispensed	442-E7
PC034	Days Supply	405-D5
PC035	Charge Amount	804-5B
PC036	Paid Amount	509-F9
PC037	Ingredient Cost/List Price	506-F6
PC038	Postage Amount Claimed	428-DS
PC039	Dispensing Fee	507-F7
PC040	Copay Amount	518-FI
PC041	Coinsurance Amount	518-FI
PC042	Deductible Amount	505-F5
PC043	Record Type	N/A

PART Ins 4005 SUBMISSIONS REQUIREMENTS

Ins 4005.01 Registration Form.

(a) Each health care claims processor and each carrier shall submit a registration form to the NHID and the DHHS, or their designee. The form shall be in the following format, and shall contain the following information:

(1) Company name;

(2) NAIC code;

(3) Mailing address;

(4) Information about whether the company conducts health insurance related business;

(5) Number of New Hampshire members covered; and

(6) Name, e-mail address and address of the person completing the form.

(b) The form shall be in the following format:

New Hampshire Insurance Department/
Department of Health and Human Services

Company
Registration Form for Submission of Data to
New Hampshire Claims Data Bank

Company Name: _____

NAIC Code: _____

Mailing Address: _____

_____

Information about whether the company currently issues health insurance policies in the state of New Hampshire. (Yes/No)

If the company issues health insurance policies in New Hampshire, what is the estimated number of members/covered lives/eligibles for one month? _____

Name, e-mail address and mailing address of person completing form:

_____
_____
_____
_____

(c) Carriers and health care claims processors shall submit a registration form by March 15, 2005, and annually thereafter.

Ins 4005.02 File Organization. The member eligibility files, medical claims file, and the pharmacy claims file shall be:

(a) Submitted to the NHID and the DHHS or their designee as separate ASCII files; and

(b) Each record terminated with a carriage return (ASCII 13), or a carriage return line feed (ASCII 13, ASCII 10).

Ins 4005.03 Filing Media.

(a) Data files shall be submitted utilizing one of the following media:

(1) CD-ROM;

(2) DVD-ROM;

(3) Secure SSL web upload interface; or

(4) Electronic transmission through a file-transfer program.

(b) E-mail attachments are not acceptable.

(c) Space permitting, multiple data files may be submitted utilizing the same media. If this is the case, the external label shall identify the multiple files.

Ins 4005.04 Transmittal Sheet.

(a) All data file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information:

(1) Identification of the health care claims processor;

(2) File name;

(3) Type of file;

(4) Data period(s);

(5) Date sent;

(6) Record count(s) for the file(s); and

(7) Contact person with telephone number and e-mail address.

(b) Carriers and health care claims processors submitting data on physical media shall affix an external label to CD-ROM or DVD on which data are sent. The label shall include:

(1) Health plan name;

(2) NHID submitted code;

(3) Contact person name;

(4) Contact person address;

(5) Contact person telephone number;

(6) Contact person e-mail address;

(7) Shipping date;

(8) Unique tracking identifier number for each file;

(9) Period beginning date;

(10) Period ending date;

(11) Record count;

(12) Date proposed;

(13) Submission date; and

(14) Any date of resubmission.

(c) The information on the transmittal sheet shall match the information on the header and trailer records, and shall conform to the following layout:

NHID Data Transmission Form

Payer Name: _____

NHID Submitter Code: _____

Contact Person Name: _____

Address: _____

_____

Telephone: _____ E-Mail: _____

File Name	Eligibility	Medical	Prescription Drugs
Period Beginning Date			
Period Ending Date			
Record Count			
Date Processed			
Original Submission			
Resubmission			

Ins 4005. 05 Testing of files. At least 30 days prior to the initial submission of the files, each carrier or health care claims processor shall submit to the NHID and the DHHS, or their designee, a data set for determining compliance with the standards for data submission. The size, based upon a calendar period of one month, or quarter of the data files submitted shall correspond to the filing period established for that health care claims processor.

Ins 4005.06 Rejection of Files. Failure to conform to the requirements for submission shall result in the rejection and return of the applicable data file(s). All rejected and returned files must be resubmitted in the appropriate, corrected form to the Department and the DHHS, or their designee, within 10 days.

Ins 4005.07 Filing Periods. The filing period for each claims data file listed shall be determined by the total number of covered lives who are New Hampshire residents for whom claims are being paid or processed by each carrier or health claims processor. For those carriers or health care claims processors having 2,000 or more New Hampshire covered lives, data shall be submitted monthly. For those carriers or health care claims processors having fewer than 2,000 New Hampshire covered lives, data shall be submitted quarterly.

Ins 4005.08 Replacement of Data Files. No carrier or health care claims processor shall replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period shall be approved by the NHID. Individual adjustment records shall be submitted with a monthly data file submission.

PART Ins 4006 COMPLIANCE WITH DATA STANDARDS

Ins 4006.01 Compliance.

(a) The NHID and the DHHS, or their designee, shall evaluate each member eligibility file, medical claims file and pharmacy claims file to determine compliance with the following data reporting requirements:

(1) The applicable code for each data element shall be included within the eligible values for the element;

(2) Coding values indicating "data not available", "data unknown", or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element;

(3) Member sex, diagnosis and procedure codes, and date of birth and all other data fields shall be consistent within an individual record; and

(4) Member identifiers shall be consistent across files.

(b) Notification. Upon completion of the evaluation, the NHID and the DHHS, or their designee shall promptly notify each carrier or health care claims processor whose data submissions do not satisfy the standards. This notification will identify the specific file and the data elements that do not satisfy the standards.

(c) Response. Each carrier or health care claims processor notified of a non-compliant data submission shall respond within 60 days of the notification by making the changes necessary to satisfy the standards.

PART Ins 4007 DATA RELEASE

Ins 4007.01 Data release. All requests for claims data, HEDIS data or CAHPS data, except those made by the NHID and the DHHS, shall be directed to the Comprehensive Health Care Information System.